DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209	(X2) MU A. BUII B. WIN	DING	ONSTRUCTION 00		DATE SURVEY COMPLETED 03/30/2012
	PROVIDER OR SUPPLIE		•	6511 N	ADDRESS, CITY, STATE, ZIP COI EBRASKA OND, IN 46323	DE .	
(X4) ID PREFIX TAG W0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Dates of survey: and 30, 2012 Facility number Provider numbe AIM number: 10 Surveyor: Chris Surveyor III/QM The following d state findings in 9.	md state licensure survey. March 26, 27, 28, 29, 000736 r: 15G209 00234620 stine Colon, Medical MRP efficiencies also reflect accordance with 460 IAC mpleted 4/13/12 by Ruth	Woo	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

STATEMEN	T OF DEFICIENCIES	FICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		15G209	B. WIN			03/30/	2012
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		6511 N	EBRASKA		
	NORTHWEST INDI			HAMM	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
W0130	The facility must clients. Therefor	OF CLIENTS RIGHTS ensure the rights of all re, the facility must ensure eatment and care of personal					
	Based on observa	ation and interview, the	W0	130	Community Services Nurse		04/29/2012
	facility failed for	2 of 2 sampled clients			and Service Coordinator will		
	and 2 additional	clients (clients #1, #2, #3			retrain staff on privacy during		
	and #4) to ensure	e privacy during			medication administration.		
	medication admi	nistration.			(4/29/12)		
					To ensure future compliance		
	Findings include	:			Community Services Nurse		
					and/or Service Coordinator		
	An evening obse	rvation was conducted at			will monitor medication		
	the group home of	on 3/28/12 from 7:00			administration at least		
	P.M. until 9:10 P	P.M At 8:30 P.M.,					
		rofessional (DSP) #1 was			bimonthly for sixty days and		
		stering client #3's			at least monthly thereafter.		
		ion in the living room					
		#2 and #4 sat in the					
		P #1 described each of					
	~	ation and the purpose of					
		while the other clients					
		oom and could hear the					
		tion. At 8:40 P.M., DSP					
		administering all of					
		ne medication in the					
		e clients #2, #3 and #4					
	_	SP #1 described each of					
	_	ations and the purpose of					
		while the other clients					
		oom and could hear the					
		tion. At 8:50 P.M., DSP					
		· ·					
	#1 was observed	administering all of					

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Event ID: 1GH211

Facility ID: 000736

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG.	00	COMPL	ETED
		15G209	B. WING	i.G		03/30/	2012
				REET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			EBRASKA		
ARC OF	NORTHWEST IND	IANA INC. THE			OND, IN 46323		
(X4) ID		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	R LSC IDENTIFYING INFORMATION)	PRE	AG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>	17	10			DATE
		me medication in the					
		le clients #1, #2 and #3					
	_	SP #1 described each of					
	client #4's medic	cations and the purpose of					
	each medication	while the other clients					
	sat in the same r	oom and could hear the					
	medical informa	tion. At 8:55 P.M., DSP					
		l administering all of					
		me medication in the					
	living room whi	le clients #1, #3 and #4					
	_	SP #1 described each of					
	_	cations and the purpose of					
		while the other clients					
		oom and could hear the					
		tion. There was no					
		ng privacy observed					
	during medication	on administration.					
	An interview wi	th the Nurse was					
	conducted at the	facility's administrative					
	office on 3/30/12	2 at 1:30 P.M The					
	Nurse indicated	all clients should have					
		nedication administration.					
	privacy during in	incurcation administration.					
	9-3-2(a)						
	9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G209	B. WIN		·	03/30/2012	
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EBRASKA		
ARC OF	NORTHWEST INDI	IANA INC, THE		HAMM	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ION
TAG W0249		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
VVUZ49	483.440(d)(1) PROGRAM IMP	LEMENTATION					
		nterdisciplinary team has					
		nt's individual program plan,					
		receive a continuous active					
		m consisting of needed d services in sufficient					
		uency to support the					
		he objectives identified in the					
	individual progra	m plan.					
			W0:	249	Service Coordinator will	04/29/20	012
	Based on observa	ation, record review, and			retrain DSPs on providing		
	interview, the fac	cility failed to implement			active treatment and family		
	written objective	es during times of			style dining according to state		
	opportunity for 2	2 of 2 sampled clients and			requirements. To ensure		
	1 additional clier	nt (clients #1, #2, and #3).			future compliance Service		
					Coordinator will observe		
	Findings include	:			dining experience bimonthly		
					for sixty days and at least		
	Clients #1, #2, a	nd #3 were observed			monthly thereafter.		
	during the group	home observation period			monthly thereafter.		
	on 3/26/12 from	5:50 A.M. until 8:30					
	A.M From 5:50	0 A.M. to 6:15 A.M.,					
	clients #1, #2 and	d #3 sat with no activity.					
	During the morn	ing meal at 6:15 A.M.,					
	clients #1, #2 and	d #3 were not observed to					
	participate in me	al preparation, which					
	consisted of cold	cereal with cut up					
	bananas, toast, sa	ausage patty and a boiled					
	egg, or set the di	ning table (help prepare					
	meals with assist	ance as needed.) At 6:30					
	A.M., DSP #2 w	as folding clients #1, #2					
	and #3's clothes	and towels. From 6:30					
	A.M. until 8:30	A.M., clients #1, #2 and					
	#3 sat in the livir	ng room without activity.					
		time periods, Direct					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CO		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		15G209	B. WING			03/30/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
∆ D C ○ E	NODTHWEST IND	IANA INC. THE			EBRASKA NND, IN 46323		
	NORTHWEST IND			VIIVIO	/ND, IIN 40323		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID	.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ional (DSP) #1 and #2					
	* *	ally walk through and					
		n clients #1, #2 and #3					
	1	meaningful active					
		ies or implement client					
	objectives.	P					
	.,						
	A review of clie	nt #1's records was					
		28/12 at 11:40 A.M A					
		ent's 4/4/11 Individual					
	Support Plan (IS	SP) indicated the					
	following object	ives which could have					
	been implemente	ed during the 3/26/12					
	morning observa	ntion period: "Will					
	relearn to write l	his namewill learn to set					
	the dining table.	will learn to fold clothes					
	or towelswill o	complete a hygiene check					
	list."						
	A review of clie	ent #2's records was					
	conducted on 3/2	28/12 at 12:15 P.M A					
	review of the cli	ent's 6/2/11 ISP indicated					
	the following ob	jectives which could have					
	_	ed during the 3/26/12					
	_	ation period: "Will					
		is own laundrywill					
	participate in art						
	_	ontinue to complete a					
	hygiene check li	st."					
	_						
		ent #3's records was					
		28/12 at 12:40 P.M A					
		ent's 6/10/11 ISP					
	indicated the fol	lowing objectives which					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL 03/30/	
		15G209	B. WING			03/30/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC. THE			EBRASKA DND, IN 46323		
				L	JND, IN 40323		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
		implemented during the		0			DITE
		observation period:					
	_	will put away items					
	dailywill chop						
	aanywin enop	ap ino ounana.					
	The Service Coo	rdinator (SC) was					
		/30/12 at 2:15 P.M The					
		objectives should be					
	implemented "du	_					
	•	ne SC further indicated					
		d #3 should have had					
		ith meaningful active					
	-	les during the 3/26/12					
	morning observa	•					
		P P					
	9-3-4(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/30/2012		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EBRASKA		
	NORTHWEST INDI			HAIVIIVIC	OND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	483.460(I)(2) DRUG STORAG The facility must biologicals locke prepared for adn Based on observation facility failed to cabinet keys for group home (clied) Findings include A morning observation for the group home of A.M. until 8:30 A until 7:20 A.M., located in client living room was in the lock while sat in the living runsupervised. A Support Profession observed entering medication area, the cabinet, and gother the desk in room.	E AND RECORDKEEPING keep all drugs and d except when being ninistration. ation and interview, the secure the medication 4 of 4 clients living at the ents #1, #2, #3 and #4). Evation was conducted at on 3/26/12 from 5:50 A.M. From 5:50 A.M. the medicine file cabinet #1, #2 and #3's unsecured observed to have the key clients #1, #2, #3 and #4 from at times to 7:20 A.M., Direct onal (DSP) #1 was	W0	TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	
	Nurse (LPN) was facility's administ at 2:15 P.M The	s conducted at the strative office on 3/30/12 are LPN indicated the should be kept on the					

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G209	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 30/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
IAG	DSP's person at all times and should never be left hanging from the medicine cabinet. 9-3-6(a)	IAG	DEFICIENCY)		DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE COMPL		
MINDILMIN	or condection	15G209	A. BUII			03/30/	
		100200	B. WIN		ADDRESS CITY STATE ZIR CODE	00/00/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE IEBRASKA		
ARC OF	NORTHWEST INDI	ANA INC, THE			OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W0440	483.470(i)(1)	LSC IDENTIFYING INFORMATION)		TAG	BEIGHARD		DATE
***************************************	EVACUATION D The facility must least quarterly fo	hold evacuation drills at reach shift of personnel.		4.40			0.4/10/2012
		review and interview, the	W0	440	Area Manager will retrain		04/19/2012
	_	conduct evacuation drills			DSPs on timeliness of fire		
	_	ng shift (7:00 A.M. to			drills. (4/19/12)		
	3:00 P.M.) during	•			To ensure future compliance		
	` •	ugh March 31st) of 2011,			Area Manager will monitor		
		ng shift (3:00 P.M. to			fire drills monthly.		
	· ·	ng the second quarter					
	` `	h June 30th) of 2011, and					
	_	ght shift (11:00 P.M. to					
	· · · · · · · · · · · · · · · · · · ·	g the fourth quarter					
	`	ugh December 31st) of					
		eted 4 of 4 clients living					
	in the facility (cli	ents #1, #2, #3 and #4.)					
	Findings include	:					
	_	ords were reviewed on					
		A.M The review failed					
		cility held a evacuation					
		#1, #2, #3 and #4 during					
	_	t (7:00 A.M. to 3:00					
	, ,	first quarter (January 1st					
	_	1st) of 2011, during the					
	,	00 P.M. to 11:00 P.M.)					
	_	d quarter (April 1st					
	_	h) of 2011, and during					
	_	ft (11:00 P.M. to 7:00					
		fourth quarter (October					
	1st through Dece	mber 31st) of 2011.					
	An Area Manage	er (AM) was interviewed					

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	OF CORRECTION OF CORRECTION 15G209	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 03/3	TE SURVEY SPLETED 30/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	on 3/30/12 at 2:15 P.M The AM indicated evacuation drills are to be run during each quarter for each shift. The AM further indicated there was no documentation available for review to indicate a drill was conducted for the mentioned shift/quarter. 9-3-7(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		15G209	B. WING			03/30/	2012
			B. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			EBRASKA		
ARC OF	NORTHWEST IND	DIANA INC, THE			OND, IN 46323		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0484	REGULATORY OF 483.480(d)(3) DINING AREAS The facility mus chairs, eating ut to meet the devictient. Based on observing facility failed for #2, #3 and #4) It provide condimentary facility failed for #2, #3 and #4) It provide condimentary facility failed for #2, #3 and #4) It provide condimentary facility failed for #2, #3 and #4) It provide condimentary facility failed for #2, #3 and #4) It provide condimentary facility failed for #2, #3 and #4) It provide condimentary failed for #4. M. until 8:30 observation Directly failed for failed failed for failed fa	AND SERVICE It equip areas with tables, tensils, and dishes designed elopmental needs of each attain and interview, the ar 4 of 4 clients (clients #1, tiving in the group home to ents at the dining table. Exercised as a conducted at an an area on 3/26/12 from 5:50 A.M During the exet Support Professional area cold cereal, boiled sausage patty. At 6:15 attailed, #2, #3 and #4 were attailed. The table was observed ar, jelly, sugar/sugar chup. DSP #1 did not put ents for the clients to use. Attailed the Service attailed was conducted on P.M The SC indicated and be put on the table for	W04	TAG		TE	04/29/2012
	9-3-8(a)						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G209	B. WING		03/30/2012
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				IEBRASKA	
ARC OF	NORTHWEST INC	DIANA INC, THE	HAMM	OND, IN 46323	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		a. building 00			COMPLETED		
15G209		B. WING			03/30/2012				
			Б. WПV		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER				EBRASKA				
ARC OF NORTHWEST INDIANA INC, THE				HAMMOND, IN 46323					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION		
TAG				TAG	DEFICIENCY)		DATE		
	A morning observation Direct (DSP) #1 prepare bananas, boiled e patties. While DS morning meal cli sat in the living r 6:15 A.M., DSP table, set each cli plate on the table #4 did not serve the sassist and the serve the serve the serve the set of the serve	AND SERVICE assure that each client eats sistent with his or her evel. ation, record review, and cility failed to assure 4 of s living in the group, #2, #3, and #4) mily style dining. : vation was conducted at on 3/26/12 from 5:50 A.M During the ct Support Professional ed cold cereal with cut up eggs, toast and sausage SP #1 prepared the ents #1, #2, #3 and #4 from with no activity. At #1 walked around the ient's prepared bowl and enter the ents #1, #2, #3 and in meal preparation and mselves.	WO	TAG	CROSS-REFERENCED TO THE APPROPRIAT				
		ds were reviewed on A.M A review of the							
		omprehensive Functional							
		cated the client was							
		capable of participating							
	in dining and meal tasks.								

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	OF CORRECTION OF CORRECTION 15G209	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 30/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	Client #2's records were reviewed on 3/28/12 at 12:15 P.M A review of the client's 6/2/11 Comprehensive Functional Assessment indicated the client was developmentally capable of participating in dining and meal tasks. Client #3's records were reviewed on 3/28/12 at 12:40 P.M A review of the client's 6/10/11 Individual Support Plan (ISP) indicated the client was developmentally capable of participating in dining and meal tasks. Client #4's records were reviewed on 3/28/12 at 12:55 P.M A review of the client's 12/12/11 ISP indicated the client was developmentally capable of participating in dining and meal tasks. An interview with the Service Coordinator (SC) was conducted on 3/30/12 at 2:15 P.M The SC indicated clients #1, #2, #3, and #4 were developmentally capable of participating in the family dining process.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1GH211

Facility ID: 000736

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